

ATTORNEY OF PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):  
 JOHN P. ROSENBERG 77946  
 JOHN P. ROSENBERG  
 6355 TOPANGA CANYON BLVD., STE. 515  
 WOODLAND HILLS, CA 91367  
 TELEPHONE: (818) 716-6400

FOR COURT USE ONLY

ATTORNEY FOR (Name):  
 L.A. SUPERIOR COURT/VAN NUYS  
 STREET ADDRESS: per rule 982.9 (a) (8):  
 MAILING ADDRESS: the address of the court is not required  
 CITY AND ZIP CODE:  
 BRANCH NAME: L.A. SUPERIOR COURT/VAN NUYS

Plaintiff GOLD  
 Defendant EGGLETON

CASE NUMBER:  
 11V05219

Ref. or File No.:  
 14-11920825

**Declaration of Diligence**

I received the within process on 09/08/11 and that after due and diligent effort, I have been unable to effect personal service on the within named party. Dates and times of attempts with reported details are listed below. Costs for diligence pertaining to substituted service is recoverable under C.C.P. 1033.5(a) (4) (B).

Servee: GRANT EGGLETON

Home address: 675 BENNET STREET  
 Simi Valley CA 93065

Business address:

09/13/11 11:27am No answer at residence on current attempt  
 09/15/11 9:19pm No answer at residence on current attempt  
 09/17/11 9:51am No answer at residence on current attempt  
 09/20/11 11:01am No answer at residence on current attempt  
 09/23/11 5:50pm No answer at residence on current attempt  
 09/26/11 8:59am SUBSTITUTED SERVICE. RECIPIENT INSTRUCTED TO DELIVER DOCUMENTS TO DEFENDANT

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Person serving (name, address, and telephone No.):  
 40011  
 J. RIOS  
 7124 Owensmouth Ave., #106,  
 Canoga Park CA 91303  
 (213) 928-7247

Fee for service: \$ 71.95  
 (recoverable per C.C.P. 1033.5(a) (4) (B))  
 Not a registered California process server.  
 Exempt from registration under B&P 22350(b).  
 Registered California process server.  
 (1) Employee or independent contractor.  
 (2) Registration No.: 523  
 (3) County: VENTURA

Date: 09/29/11

(Signature)

Form Adopted by rule 982  
 982.9(a) (5)

**Declaration of Diligence**

14-11920825

GO: 14

Plaintiff (list names): GOLD, KATHY

**(4) You must ask the Defendant (in person, in writing, or by phone) to pay you before you sue.**

Have you done this?  Yes  No

If no, explain why not:

**(5) Why are you filing your claim at this courthouse?**

This courthouse covers the area (Check the one that applies):

a.  (1) Where the Defendant lives or does business.

(2) Where the Plaintiff's property was damaged.

(3) Where the Plaintiff was injured.

(4) Where a contract (written or spoken) was made, signed, performed, or broken by the Defendant or where the Defendant lived or did business when the Defendant made the contract.

b.  Where the buyer or lessee signed the contract, lives now, or lived when the contract was made, if this claim is about an offer or contract for personal, family, or household goods, services, or loans. (Code Civ. Proc., 395(b).)

c.  Where the buyer signed the contract, lives now, or lived when the contract was made, if this claim is about a retail installment contract (like a credit card). (Civil Code, 1812.10.)

d.  Where the buyer signed the contract, lives now, or lived when the contract was made, or where the vehicle is permanently garaged, if this claim is about a vehicle finance sale. (Civil Code, 2984.4.)

e.  Other (specify):

**(6) List the zip code of the place checked in (5) above (if you know): 91423**

**(7) Is your claim about an attorney-client fee dispute?  Yes  No**

If yes, and if you have had arbitration, fill out Form SC-101, attach it to this form and check here:

**(8) Are you suing a public entity?  Yes  No**

If yes, you must file a written claim with the entity first.  A claim was filed on (date):

If the public entity denies your claim or does not answer within the time allowed by law, you can file this form.

**(9) Have you filed more than 12 other small claims within the last 12 months in California?**

Yes  No If yes, the filing fee for this case will be higher.

**(10) I understand that by filing a claim in small claims court, I have no right to appeal this claim.**

**(11) I have not filed, and understand that I cannot file, more than two small claims cases for more than \$2,500 in California during this calendar year.**

I declare, under penalty of perjury under California State law, that the information above and on any attachments to this form is true and correct.

Date: 09/02/2011

Plaintiff types or prints name here

Plaintiff signs here

Date:

Second Plaintiff types or prints name here

Second Plaintiff signs here

**Requests for Accommodations**

Assistive listening systems, computer-assisted, real-time captioning, or sign language interpreter services are available if you ask least 5 days before the trial. Contact the clerk's office for Form MC-410, Request for Accommodations by Persons With Disabilities and Response. (Civil Code, 54.8.)

## SC-100 Plaintiff's Claim and ORDER to Go to Small Claims Court

**Notice to the person being sued:**

- You are the Defendant if your name is listed in (2) on page 2 of this form. The person suing you is the Plaintiff, listed in (1) on page 2.
  - You and the Plaintiff must go to court on the trial date listed below. If you do not go to court, you may lose the case.
  - If you lose, the court can order that your wages, money, or property be taken to pay this claim.
  - Bring witnesses, receipts, and any evidence you need to prove your claim.

### Aviso al Demandando:

- Usted es el Demandado si su nombre figura en (2) de la pagina 2 de este formulario. La persona que lo demanda es el Demandante, la que figura en (1) de la pagina 2.
  - Usted y el Demandante tienen que presentarse en la corte en la fecha del juicio indicada a continuacion. Si no se presenta, puede perder el caso.
  - Si pierde el caso la corte podria ordenar que le quiten de su sueldo, dinero u otros bienes para pagar este reclamo.
  - Lleve testigos, recibos y cualquier otra prueba que necesite para probar su caso.
  - Lea este formulario y todas las paginas adjuntas para entender la demanda en su contra y para proteger sus derechos.

6230 SYLMAR AVENUE  
VAN NUYS, CA. 91401  
(818) 374-2901

Clerk fills in case number and case name

Case Number: LAV 11V05219
Case Name: GOLD, KATHY VS EGGLETON, G

### Order to Go to Court

The people in (1) and (2) must go to court: (Clerk fills out section below.)

=====  
TRIAL DATE 10/18/2011 TIME 08:30 AM DEPARTMENT NWZ LOCATION ROOM 320, THIRD FL  
=====

Date: 09/02/2011 JOHN A. CLARKE, Executive Officer/Clerk  
By: SANDRA ALARCON Deputy

**Instructions for the person suing:**

- INSTRUCTIONS FOR THE PERSON SUING:**

  - You are the Plaintiff. The person you are suing is the Defendant.
  - Before you fill out this form, read Form SC-100-INFO, *Information for the Plaintiff* to know your rights. Get SC-100-INFO at any courthouse or county law library, or go to: [www.courtinfo.ca.gov/forms](http://www.courtinfo.ca.gov/forms)
  - Fill out pages 2 and 3 of this form. Then make copies of all pages of this form. (Make 1 copy for each party named in this case and an extra copy for yourself.) Take or mail the original and these copies to the court clerk's office and pay the filing fee. The clerk will write the date of your trial in the box above.
  - You must have someone at least 18--not you or anyone else listed in this case--give each Defendant a court-stamped copy of all 5 pages of this form and any pages this form tells you to attach. There are special rules for "serving," or delivering, this form to public entities, associations, and some businesses. See Forms SC-104, SC-104B, and SC-104C.
  - Go to court on your trial date listed above. Bring witnesses, receipts, and any evidence you need to prove your case.

Judicial Council of California, [www.courts.ca.gov](http://www.courts.ca.gov)  
Revised January 1, 2011, Mandatory Form  
Code of Civil Procedure, 116.110 et seq.,  
116.220(c), 116.340(g)

**Plaintiff's Claim and ORDER  
to Go to Small Claims Court  
(Small Claims)**

SC-100, Page 1 of 5  
-->

Plaintiff's Claim and ORDER  
to Go to Small Claims Court

## Notice to the person being sued:

- You are the Defendant if your name is listed in (2) on page 2 of this form. The person suing you is the Plaintiff, listed in (1) on page 2.
- You and the Plaintiff must go to court on the trial date listed below. If you do not go to court, you may lose the case.
- If you lose, the court can order that your wages, money, or property be taken to pay this claim.
- Bring witnesses, receipts, and any evidence you need to prove your case.
- Read this form and all pages attached to understand the claim against you and to protect your rights.

## Aviso al Demandado:

- Usted es el Demandado si su nombre figura en (2) de la página 2 de este formulario. La persona que lo demanda es el Demandante, la que figura en (1) de la página 2.
- Usted y el Demandante tienen que presentarse en la corte en la fecha del juicio indicada a continuación. Si no se presenta, puede perder el caso.
- Si pierde el caso la corte podría ordenar que le quiten de su sueldo, dinero u otros bienes para pagar este reclamo.
- Lleve testigos, recibos y cualquier otra prueba que necesite para probar su caso.
- Lea este formulario y todas las páginas adjuntas para entender la demanda en su contra y para proteger sus derechos.

## Order to Go to Court

The people in (1) and (2) must go to court: (Clerk fills out section below.)

Trial Date	Date 1. 10-18-11	Time 8:30	Department 2	Name and address of court if different from above NORTHWEST DISTRICT - EAST BLDG. 6230 SYLMAR AVENUE VAN NUYS, CA 91401
2.				
3.				
Date:	10-21-11	Clerk, by JOHN A. CLARKE	John A. Clarke, Deputy	

## Instructions for the person suing:

- You are the Plaintiff. The person you are suing is the Defendant.
- Before you fill out this form, read Form SC-100-INFO, *Information for the Plaintiff*, to know your rights. Get SC-100-INFO at any courthouse or county law library, or go to: [www.courtinfo.ca.gov/forms](http://www.courtinfo.ca.gov/forms)
- Fill out pages 2 and 3 of this form. Then make copies of all pages of this form. (Make 1 copy for each party named in this case and an extra copy for yourself.) Take or mail the original and these copies to the court clerk's office and pay the filing fee. The clerk will write the date of your trial in the box above.
- You must have someone at least 18—not you or anyone else listed in this case—give each Defendant a court-stamped copy of all 5 pages of this form and any pages this form tells you to attach. There are special rules for "serving," or delivering, this form to public entities, associations, and some businesses. See Forms SC-104, SC-104B, and SC-104C.
- Go to court on your trial date listed above. Bring witnesses, receipts, and any evidence you need to prove your case.

SEP 02 2011

John A. Clark, Executive Officer/Clerk  
John A. Clark, Executive Officer/Clerk  
BY SANDRA ALARCON, DEPUTY

Fill in court name and street address:

Superior Court of California, County of  
LOS ANGELES  
Los Angeles Superior Cou  
6230 Sylmar Avenue  
same  
Van Nuys, California 914  
NORTHWEST DISTRICT

Clerk fills in case number and case name:

Case Number:  
11V 05219

Case Name:  
GOLD v. EDDLETON

Plaintiff (list names): KATHY GOLD**1 The Plaintiff (the person, business, or public entity that is suing) is:**Name: KATHY GOLD Phone: (818)358-3865Street address: c/o 6355 Topanga Canyon Blvd #515, Woodland Hills, CA 91367  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_Mailing address (if different): Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_**If more than one Plaintiff, list next Plaintiff here:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Street address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_Mailing address (if different): Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ *Check here if more than 2 Plaintiffs and attach Form SC-100A.* *Check here if either Plaintiff listed above is doing business under a fictitious name. If so, attach Form SC-103.***2 The Defendant (the person, business, or public entity being sued) is:**Name: GRANT EGGLETON Phone: (310)889-4987Street address: 675 Bennet Street \_\_\_\_\_ Simi Valley, CA 93065  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_Mailing address (if different): Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_**If more than one Defendant, list next Defendant here:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Street address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_Mailing address (if different): Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ *Check here if more than 2 Defendants and attach Form SC-100A.* *Check here if any Defendant is on active military duty, and write his or her name here: \_\_\_\_\_***3 The Plaintiff claims the Defendant owes \$ 7,500.00. (Explain below):**a. Why does the Defendant owe the Plaintiff money? Defendant rear-ended Plaintiff on the 101 freeway near Woodman Avenue, Sherman Oaks, California, causing Plaintiff bodily injuries requiring medical care.b. When did this happen? (Date): 11-16-10If no specific date, give the time period: Date started: \_\_\_\_\_ Through: \_\_\_\_\_c. How did you calculate the money owed to you? (Do not include court costs or fees for service.) see attached SC-100. *Check here if you need more space. Attach one sheet of paper or Form MC-031 and write "SC-100, Item 3" at the top.*

Plaintiff (list names): KATHY GOLD

- 4 You must ask the Defendant (in person, in writing, or by phone) to pay you before you sue. Have you done this?  Yes  No  
If no, explain why not: \_\_\_\_\_

5 Why are you filing your claim at this courthouse?

This courthouse covers the area (check the one that applies):

- a.  (1) Where the Defendant lives or does business. (4) Where a contract (written or spoken) was made, signed, performed, or broken by the Defendant or where the Defendant lived or did business when the Defendant made the contract.  
 (2) Where the Plaintiff's property was damaged.  
 (3) Where the Plaintiff was injured.
- b.  Where the buyer or lessee signed the contract, lives now, or lived when the contract was made, if this claim is about an offer or contract for personal, family, or household goods, services, or loans. (Code Civ. Proc., § 395(b).)
- c.  Where the buyer signed the contract, lives now, or lived when the contract was made, if this claim is about a retail installment contract (like a credit card). (Civil Code, § 1812.10.)
- d.  Where the buyer signed the contract, lives now, or lived when the contract was made, or where the vehicle is permanently garaged, if this claim is about a vehicle finance sale. (Civil Code, § 2984.4.)
- e.  Other (specify): \_\_\_\_\_

- 6 List the zip code of the place checked in 5 above (if you know): 91423

- 7 Is your claim about an attorney-client fee dispute?  Yes  No

If yes, and if you have had arbitration, fill out Form SC-101, attach it to this form, and check here:

- 8 Are you suing a public entity?  Yes  No

If yes, you must file a written claim with the entity first.  A claim was filed on (date): \_\_\_\_\_

If the public entity denies your claim or does not answer within the time allowed by law, you can file this form.

- 9 Have you filed more than 12 other small claims within the last 12 months in California?

Yes  No If yes, the filing fee for this case will be higher.

- 10 I understand that by filing a claim in small claims court, I have no right to appeal this claim.

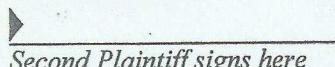
- 11 I have not filed, and understand that I cannot file, more than two small claims cases for more than \$2,500 in California during this calendar year.

I declare, under penalty of perjury under California State law, that the information above and on any attachments to this form is true and correct.

Date: 8/22/11 KATHY GOLD  
Plaintiff types or prints name here

  
Plaintiff signs here

Date: \_\_\_\_\_  
Second Plaintiff types or prints name here

  
Second Plaintiff signs here



Requests for Accommodations

Assistive listening systems, computer-assisted, real-time captioning, or sign language interpreter services are available if you ask at least 5 days before the trial. Contact the clerk's office for Form MC-410, Request for Accommodations by Persons With Disabilities and Response. (Civil Code, § 54.8.)

PETITIONER/PLAINTIFF: KATHY GOLD  
RESPONDENT/DEFENDANT: GRANT EGGLETON

CASE NUMBER:

SC-100, Item 3

3(c) Medical Bills: Orthopedic Medical Center	\$1,568.00
Valley PT & Rehab	\$2,795.00
Prescription Charges	33.88
TOTAL MEDICAL BILLS	\$4,396.88
General Damages for pain and suffering	\$3,103.12



**Ambulatory Care Network**  
HEALTH SERVICES • LOS ANGELES COUNTY

**MID-VALLEY COMPREHENSIVE HEALTH CENTER RELEASE OF INFORMATION**

7515 Van Nuys Blvd  
Van Nuys, CA 91405  
Office - 1(818)947-4044  
FAX- 1(818)989-8858

**INVOICE**

Attached are the photo copies you requested regarding:

Date: 10/30/15

Patient Name	GOLD, Kathleen	MV Medical Record	233-35-41	DOB	12/17/1966
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Our photocopy fee is \$0.25 per page

Pages copied	11	x .25	= Total amount due for these copies	\$2.75
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1:

County of Los Angeles  
Olive View/UCLA Medical Center  
14445 Olive View Drive  
Sylmar, CA 91342  
(818) 364-3189

Date: 10/30/2015 Receipt: 732758

NAME: GOLD, KATHLEEN/2333541

ITEM: SALE OF PHOTOCOPIES

Total Payment: 2.75

Payment Form: CHECK

Comprehensive Health Center  
Van Nuys Blvd.  
CA 91405  
Medical Records Dept.  
# 95-6000927W

PAID OCT 30 2015  
R# 732758 OK

Health Center -Release of Information Dept.

\*\*\* Thank You \*\*\*  
CA

, 7515 Van Nuys Blvd., Van Nuys, CA 91405; (818) 947-4044



**Ambulatory Care Network**  
HEALTH SERVICES • LOS ANGELES COUNTY

**MID-VALLEY COMPREHENSIVE HEALTH CENTER RELEASE OF INFORMATION**

7515 Van Nuys Blvd  
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Office - 1(818)947-4044  
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**INVOICE**

Attached are the photo copies you requested regarding:

Date: 10/30/15

Patient Name	GOLD, Kathleen	MV Medical Record	233-35-41	DOB	12/17/1966
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Our photocopy fee is **\$0.25** per page

Total pages copied	11	x .25	= Total amount due for these copies	\$2.75
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Please make check payable to:

Mid-Valley Comprehensive Health Center  
7515 Van Nuys Blvd.  
Van Nuys, CA 91405  
Attn: Medical Records Dept.  
**TAX ID# 95-6000927W**

PAID OCT 30 2015  
R# 732758 OK

Thank You,  
Mid-Valley Comprehensive Health Center -Release of Information Dept.

# Exhibit A - Landini

COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICE

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

MEDICAL RECORD NUMBER: \_\_\_\_\_ DATE: 10-21-15

RELATIONSHIP TO PATIENT:  SELF  PARENT  LEGAL GUARDIAN  OTHER: \_\_\_\_\_

### Patient Information

Gold Last Name Kathleen First BS12 MI MA Date of Birth 12/17/66  
 11100-8 Address Sepulveda Blvd City Mission Hills State CA Zip 91345 Phone (818)235-6370

### HEREBY AUTHORIZES

- |   |   |
|---|---|
| <input type="checkbox"/> LAC-USC Medical Center     | <input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center             |
| <input type="checkbox"/> Olive View Medical Center  | <input type="checkbox"/> High Desert Multi-Service Ambulatory Care Center             |
| <input type="checkbox"/> Harbor-UCLA Medical Center | <input type="checkbox"/> Martin Luther King, Jr. Multi-Service Ambulatory Care Center |
| <input type="checkbox"/> CHC/Health Center:         |   |

Other: MVHC Facility Name Call to P/U Street Address City State Zip Code

### To Release Protected Health Information To:

Name of Facility/Health Care Provider/Plan/Other

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

for the time period beginning, All Records, and ending 10/21/15. Date \_\_\_\_\_

EXPIRATION DATE: This authorization is valid until the following date: 4/21/2016

### INFORMATION TO BE DISCLOSED

#### PLEASE CHECK ALL APPROPRIATE BOXES:

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Mental Illness or Mental Health Assessment |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Drug and/or Alcohol Abuse Treatment        |
| <input type="checkbox"/> Consultation                  | <input type="checkbox"/> HIV/AIDS                                   |
| <input type="checkbox"/> Operative Report              | <input type="checkbox"/> Sexually Transmitted Disease(s)            |
| <input type="checkbox"/> Radiology Report              | <input type="checkbox"/> EKG Report                                 |
| <input type="checkbox"/> Radiology Films               | <input type="checkbox"/> EEG Report                                 |
| <input type="checkbox"/> Laboratory / Diagnostic Tests | <input type="checkbox"/> Summary of Medical History / Treatment     |
| <input type="checkbox"/> Medical Progress Notes        |   |

Other (Please Specify): All Records

MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION  
 233 35 41 DOB: 12/17/1966  
 GOLD, KATHLEEN PHWR  
 PREF. LANG: ENGLISH SEX: F

MRUN 233-35-41

NAME Gold, Kathleen

DOB/GENDER 12/17/1966 F

AUTHORIZATION FOR USE AND DISCLOSURE  
 OF PROTECTED HEALTH INFORMATION

PAGE 1 OF 2



T-HS1015

**THE PURPOSE OF THE DISCLOSURE - PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE**Personal

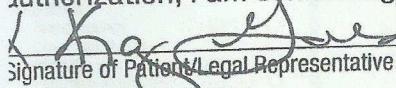
understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**OUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

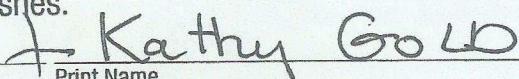
**Right to Receive a Copy of This Authorization** – I understand that if I sign this authorization, I will be provided with a signed copy of the form.

**CONDITIONS:** I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DHS may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.



Signature of Patient/Legal Representative

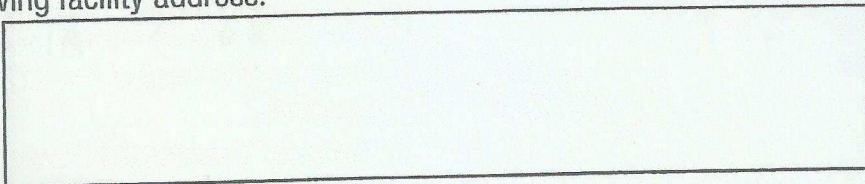


Print Name

If signed by other than the patient, state relationship and authority to do so:

Date: 10/21/15Witness: C JenkinsPrint Name: C Jenkins

**Right to Revoke This Authorization** – I understand that I have the right to revoke this Authorization at any time by telling DHS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to the following facility address:



I also understand that a revocation will not affect the ability of DHS or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

**REVOCATION OF AUTHORIZATION**

Signature of Patient/Legal Representative:

If signed by other than patient, state relationship and authority to do so:

MRUN

NAME

DOB/GENDER



T-HS1015

FILE IN MEDICAL RECORD

**AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**  
PAGE 2 OF 2 HS1015 (4-14)

AMBULATORY CARE NETWORK  
MID-VALLEY CHC, SAN FERNANDO AND GLENDALE HEALTH CENTERS, VAUGHN SBCA=Abnormal NO MARK=NOT EXAMINED  
(N=Normal or No significant findings.)GENERAL APPEARANCE  
Appearance  
Adenopathy

N A

## HEAD

Scalp  
Ears - External  
Internal  
Eyes-General  
Fundoscopic  
Oral cavity NECK  
ThyroidGang. Left  
 THORAX, AND  
Chest WallLung 1/2  
 HEART  
PMI  
Rate / Rhythm  
Murmur  
Galloping  
JVP LUNGS  
Auscultation  
Percussion  
Excursions BREASTS  
Skin changes  
Nipple / Areola  
Axilla  
Masses ABDOMEN  
Bowel Sounds  
Liver/Spleen Size  
Masses  
Abdomen Tenderness  
CVA tenderness MUSCULOSKELETAL  
Extremities  
Clubbing  
Cyanosis  
Edema  
Joints  
Back 

FOOT EXAM

 VASCULAR SYSTEM  
Carotids  
Abdominal Aorta  
Femorals  
Posterior tibials GENITALIA  
Male  
Penis  
Testicles & epididymis Female  
External Genitalia  
Vagina  
Cervix  
Uterus  
Adnexa ANORECTAL  
External Appearance  
Digital Exam  
Prostate Gland NEUROLOGICAL  
Alertness & orientation  
Cranial nerves (II-XII)  
Motor  
Sensory  
DTR  
Cerebellar  
Memory  
Speech 

(See over for Assessment, Plan, Orders)

## Nursing Intake

BP	Temp	HR	RR	*Pain Level	Pain Goal	Pain Tool	Pain Location
119/53	98.3	74	16	0/10	0/10	0-10 Faces	<input type="checkbox"/> Back <input type="checkbox"/> Head Other:

WEIGHT: 180 HEIGHT: BMI: LMP: Allergies: NKDA

Currently Smoking:  Yes  No

Reason for visit: (Circle Applicable):	New / IHA	Return	Same Day	Interpreter
<b>Annual Fall Assessment:</b>				
1. Has there been an unexpected fall in the preceding 3 months?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
2. Does patient have an unstable gait (with or without assistance / assistive device)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
3. Does patient have any changes in vision, strength or sensation/loss of feeling?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
4. Is patient on meds that may lead to fall risk (e.g. narcotics or cardiac-related drugs)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
If any of the questions 1 to 4 is marked as "yes" - Fall precaution taken and education provided <input type="checkbox"/> Yes				
Signature: Luisa Arevalo CMA NA/CMA/LVN / RN Date/Time: JAN 22 2014 6:56				

479 for DHA/pz.

of 5 lbs since 9/13  
per pt the crown fell off for her left  
molar, left with big cavity.

Plans to quit tobacco now  
down to last pack. Pers  
Nisentri patch or by med.

Td 7/10pm

(A) DHA/pz

shirts

IGT.

↓ Catt.

4/7 of older Ds.

11/05/13.  
Hb 12.5% 6.0%.  
TSH 1.48.  
hprt 189 (2/14).  
CBC wbc  
Non Hgb 142  
A.  
(37) 102/14  
4.1 28 0.7%  
Cat 8.71  
hprt 142  
TP 6.3

PATIENT DATA - Imprint or Print Legibly	
Name:	
MR:	MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION 233 35 41 DOB: 12/17/1966
Date:	GOLD, KATHLEEN ER
Ward:	PREF. LANG: ENGLISH SEX: F
Req. Loc. Code:	



T-MV02

FILE IN MEDICAL RECORD

PAGE 1 OF 2

MV02 (7-13)

ADULT VISIT RECORD

add oral I Dose to Rx  
to call 1800 no info for Rx  
Correllip.

#### NURSING NOTES

##### Labs

Specimen obtained and sent for:

Pap  Other:

Lab slips given with instructions # (1)

Order #'s 1432216

Order #'s

Order #'s

##### Radiology

X-ray slips given with instructions

Order #'s

##### Immunizations

No contraindications present

Immunizations given:

TDAP  dT  Pneumovax  
 PPD  Flu  Zoster vaccine  
 Other

##### TB Testing

PPD placed left forearm. Return 48-72 hrs

##### Other Instructions

MD-orders reinforced

Follow-up instructions given

Medications (# ) Or Rx's (# )

given with instructions

17-1800-0000

Referrals (explained, submitted)

##### Optometry Screening:

Retinal camera  Ophthalmology

Social Work  Health Ed  Care Manager

Service Coordinator

##### Patient Education

Topic:	Counsel	Pamphlet	Video
Low salt diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low K+ diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Mgt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orders: <input type="checkbox"/> Today <input checked="" type="checkbox"/> One week before next visit <input type="checkbox"/> In weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pap <input type="checkbox"/> Lipid panel <input type="checkbox"/> Urine hcg <input type="checkbox"/> Cr <input type="checkbox"/> CBC w/o diff <input checked="" type="checkbox"/> HgbA1C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> FOBT <input type="checkbox"/> Liver panel <input type="checkbox"/> Urine MA/Cr <input type="checkbox"/> Bun <input type="checkbox"/> CBC w/ diff <input type="checkbox"/> Gluc. (poc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EKG <input type="checkbox"/> ALT <input type="checkbox"/> Urine GC/chl <input type="checkbox"/> K <input type="checkbox"/> Hgb (poc) <input type="checkbox"/> Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pulse ox <input type="checkbox"/> PT / INR <input type="checkbox"/> Urine C & S <input type="checkbox"/> BMP <input type="checkbox"/> TSH <input type="checkbox"/> B12 / folate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chlamydia screen (age 15-24) <input type="checkbox"/> Urinalysis <input type="checkbox"/> CMP <input type="checkbox"/> FT4 <input type="checkbox"/> PFT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiology (indicate reason): <input type="checkbox"/> CXR PA&LAT <input type="checkbox"/> CXR one view <input type="checkbox"/> screening mammo <input type="checkbox"/> BE <input type="checkbox"/> UGI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: <i>refers</i> Indication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations: <input checked="" type="checkbox"/> TDAP 0.5cc IM <input type="checkbox"/> Pneumovax 0.5cc IM <input type="checkbox"/> dT 0.5cc IM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PPD 0.1cc ID <input type="checkbox"/> Flu vaccine 0.5cc IM <input type="checkbox"/> Zoster vaccine 0.5cc SQ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other <i>refers</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral(s) to: <input type="checkbox"/> Health Educator <input type="checkbox"/> Care Manager <input type="checkbox"/> DM ophthalmology <input type="checkbox"/> Podiatry (MV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Social Work <input type="checkbox"/> Nutrition counseling <input type="checkbox"/> DM eye screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Service Coordinator <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women's for: <input type="checkbox"/> Screening only <input type="checkbox"/> Other: <i>Dental close 4 months</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow-up: <input type="checkbox"/> With PCP in / <input type="checkbox"/> for IHA in:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider Name: <i>M. Chinn</i> Time: <i>8:00am</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider Sign: <i>M. Chinn 1/22/14</i> MD / NP / PA / Student	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending Signature: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addendum: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signature _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date/Time: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient given instructions/education by nurse / CMA and demonstrated understanding by:

verbalization of understanding

repeating information

demonstrating activity

## AMBULATORY CARE NETWORK

MID-VALLEY CHC, SAN FERNANDO AND GLENDALE HEALTH CENTERS, VAUGHN SBC

Abnormal NO MARK=NOT EXAMINED)  
=Normal or No significant findings.)

N A

## ENERAL APPEARANCE

Appearance

Adenopathy

## EAD

Scalp

Ears - External

Internal

Eyes-General

Fundoscopic

Oral cavity

## ECK

Thyroid

HORAX, AND

Chest Wall

## EART

PMI

Rate / Rhythm

Murmur

Gallopp

JVP

## UNGS

Auscultation

Percussion

Excursions

## REASTS

Skin changes

Nipple / Areola

Axilla

Masses

## BDOMEN

Bowel Sounds

Liver/Spleen Size

Masses

Abdomen Tenderness

CVA tenderness

## MUSCULOSKELETAL

Extremities

Clubbing

Cyanosis

Edema

Joints

Back

## D0T EXAM

Male

Penis

Testicles &amp; epididymis

Female

External Genitalia

Vagina

Cervix

Uterus

Adnexa

## NORECTAL

External Appearance

Digital Exam

Prostate Gland

## EUROLOGICAL

Alertness &amp; orientation

Cranial nerves (II-XII)

Motor

Sensory

DTR

Cerebellar

Memory

Speech

See over for Assessment, Plan, Orders)

## Nursing Intake

BP	Temp	HR	RR	*Pain Level	Pain Goal	Pain Tool	Pain Location
114/64	98.2	74	16	5/10	0/10	0-10 Faces	<input type="checkbox"/> Back <input checked="" type="checkbox"/> Head Other:

WEIGHT: 183 HEIGHT: 5'2 BMI: 33	LMP: 07/28	Allergies: Food allergies NKD		
Currently Smoking: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Reason for visit: (Circle Applicable):	New / IHA	Return	Same Day	Interpreter
<b>Annual Fall Assessment:</b> 1. Has there been an unexpected fall in the preceding 3 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2. Does patient have an unstable gait (with or without assistance / assistive device)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Does patient have any changes in vision, strength or sensation/loss of feeling? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 4. Is patient on meds that may lead to fall risk (e.g. narcotics or cardiac-related drugs)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If any of the questions 1 to 4 is marked as "yes" - Fall precaution taken and education provided <input checked="" type="checkbox"/> Yes				
Signature: Vilma Toscano, NA		Date/Time: 8:42 SEP 23 2013		

46q problem mil.

Need a letter states that she can not sign the waiver for the pesticide spray in her home.

Having small claim law suit over landlord her room/apartment is filled with cockroaches and mole. court has order the cleanup and pest control company gives her paper to sign the waiver in case of any unexpected reactions. She wants to find out whether she is allergic or not.

allergy - white egg/ soy

PMHx - Celiac 95.

C/ neck pain, headache due to stress 5 ds.  
C/ mild stuffy nose (+)(A) Cervical strain  
Tension headache

## PATIENT DATA - Imprint or Print Legibly

Name:

MID-VALLEY COMP. - CENTER PT. IDENTIFICATION

233 35 41 DOB: 12/17/1966

GOLD, KATHLEEN PHWR

PREF. LANG: ENGLISH SEX: F



Req. Loc. Code:

## ADULT VISIT RECORD



T-MV02

FILE IN MEDICAL RECORD

PAGE 1 OF 2

MV02 (7-13)

to call local poison controlled  
from the phone book.

motor comp tip to the prn for

per.

NURSING NOTES			
<input type="checkbox"/> Specimen obtained and sent for: <input type="checkbox"/> Pap <input type="checkbox"/> Other: _____ <input checked="" type="checkbox"/> Lab slips given with instructions # ( ) Order #'s <u>L143638-642</u> Order #'s <u>L1436417</u> Order #'s _____			
<b>Radiology</b> <input type="checkbox"/> X-ray slips given with instructions Order #'s <u>5</u>			
<b>Immunizations</b> <input type="checkbox"/> No contraindications present Immunizations given: <input type="checkbox"/> TDAP <input type="checkbox"/> dT <input type="checkbox"/> Pneumovax <input type="checkbox"/> PPD <input type="checkbox"/> Flu <input type="checkbox"/> Zoster vaccine <input type="checkbox"/> Other _____			
<b>TB Testing</b> <input type="checkbox"/> PPD placed left forearm. Return 48-72 hrs			
<b>Other Instructions</b> <input checked="" type="checkbox"/> LMB orders reinforced <input type="checkbox"/> Follow-up instructions given <input checked="" type="checkbox"/> Medications (# ) Or Rx's (# ) given with instructions <u>RTC is selected</u>			
<b>Referrals (explained, submitted)</b> Optometry Screening: <input type="checkbox"/> Retinal camera <input checked="" type="checkbox"/> Ophthalmology			
<input type="checkbox"/> Social Work <input type="checkbox"/> Health Ed <input type="checkbox"/> Care Manager <input type="checkbox"/> Service Coordinator			
<b>Patient Education</b> Topic: _____ Low salt diet <input type="checkbox"/> Counsel <input type="checkbox"/> Pamphlet <input type="checkbox"/> Video Low K+ diet <input type="checkbox"/> _____ TB <input type="checkbox"/> _____ Pain Mgt. <input checked="" type="checkbox"/> Counsel <input type="checkbox"/> _____ Dyslipidemia <input type="checkbox"/> _____ Diabetic diet <input type="checkbox"/> _____ Exercise <input type="checkbox"/> _____ High fiber <input type="checkbox"/> _____ Tobacco cessation <input type="checkbox"/> _____ Staying Healthy Ed. <input type="checkbox"/> _____ Self-Mgt / Smart goals <input type="checkbox"/> _____			
Patient given instructions/education by nurse / CMA and demonstrated understanding by: <input checked="" type="checkbox"/> verbalization of understanding <input checked="" type="checkbox"/> repeating information <input type="checkbox"/> demonstrating activity			

Education in Clinic: N = Nurse to give handout / education P = Discussed by provider

N P	N P	N P	N P
<input type="checkbox"/> <input type="checkbox"/> Low salt diet	<input type="checkbox"/> <input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> <input type="checkbox"/> Emerg contracep <55	<input type="checkbox"/> <input type="checkbox"/> Lab results
<input type="checkbox"/> <input type="checkbox"/> Low K+ diet	<input type="checkbox"/> <input type="checkbox"/> Diabetic diet	<input type="checkbox"/> <input type="checkbox"/> Radiology results	<input type="checkbox"/> <input type="checkbox"/> GERD
<input type="checkbox"/> <input type="checkbox"/> TB Assessment	<input type="checkbox"/> <input type="checkbox"/> Exercise	<input type="checkbox"/> <input type="checkbox"/> Tobacco cessation	<input type="checkbox"/> <input type="checkbox"/> Back pain
<input type="checkbox"/> <input type="checkbox"/> Pain Mgt.	<input type="checkbox"/> <input type="checkbox"/> High Fiber	<input type="checkbox"/> <input type="checkbox"/> Staying Healthy Ed.	<input type="checkbox"/> <input type="checkbox"/> Self-Mgt / Smart goals
<input type="checkbox"/> <input type="checkbox"/> Other _____			

Orders:	<input type="checkbox"/> Today	<input type="checkbox"/> One week before next visit	<input type="checkbox"/> In _____ weeks	<input type="checkbox"/> Fasting	<u>Shall</u>
	<input type="checkbox"/> Pap	<input checked="" type="checkbox"/> Lipid panel	<input type="checkbox"/> Urine hcg	<input type="checkbox"/> Cr	<input type="checkbox"/> HgbA1C
	<input type="checkbox"/> FOBT	<input checked="" type="checkbox"/> Liver panel	<input type="checkbox"/> Urine MA/Cr	<input type="checkbox"/> Bun	<input type="checkbox"/> CBC w/o diff
	<input type="checkbox"/> EKG	<input type="checkbox"/> ALT	<input type="checkbox"/> Urine GC/chl	<input type="checkbox"/> K	<input type="checkbox"/> CBC w/ diff
	<input type="checkbox"/> Pulse ox	<input type="checkbox"/> PT / INR	<input type="checkbox"/> Urine C & S	<input checked="" type="checkbox"/> BMP	<input type="checkbox"/> Hgb (poc)
	<input type="checkbox"/> Chlamydia screen (age 15-24)		<input type="checkbox"/> Urinalysis	<input type="checkbox"/> CMP	<input type="checkbox"/> Gluc. (poc)
	<input type="checkbox"/> Other: _____			<input type="checkbox"/> TSH	<input type="checkbox"/> Glucose
				<input type="checkbox"/> FT4	<input type="checkbox"/> B12 / folate
					<input type="checkbox"/> PFT

Radiology (indicate reason):  CXR PA&LAT       CXR one view       screening mammo       BE       UGI

Other: \_\_\_\_\_ Indication: \_\_\_\_\_

Immunizations:  TDAP 0.5cc IM       Pneumovax 0.5cc IM  
 PPD 0.1cc ID       Flu vaccine 0.5cc IM       dT 0.5cc IM  
 Other       Zoster vaccine 0.5cc SQ

Referral(s) to:  Health Educator       Care Manager       DM ophthalmology       Podiatry (MV)  
 Social Work       Nutrition counseling       DM eye screening  
 Service Coordinator       Other \_\_\_\_\_

Women's for:  Screening only       Other: \_\_\_\_\_

Follow-up:  With PCP in /  for IHA in: as scheduled

Provider Name: <u>M. Chiu</u>	Time: <u>10:30 AM</u>	Nurse / CMA Name: <u>Aria Melara, CMA</u>
Provider Sign: <u>M. Chiu</u>	<u>9/23/13</u>	Nurse / CMA Signature: <u>P</u>
Attending Name: _____	MD NP PA Student: <u>MD NP PA Student</u>	Date / Time: <u>9.23.13 @ 10:45</u>
Attending Signature: _____		

Addendum: Call California Poison control 1-800-411-8080 if need

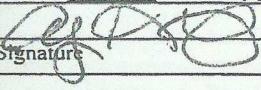
Signature Aria Melara, CMA

Date/Time: 9.23.13 @ 10:45

## DENTAL CLINIC – VALLEYCARE MEDICAL CENTER

Date: 5-13-14 Time: 10:35	<input type="checkbox"/> IP <input checked="" type="checkbox"/> OP	<input type="checkbox"/> Unable to assess PAIN/VS due to patient disability
Visit Type: <input type="checkbox"/> New <input checked="" type="checkbox"/> Established <input type="checkbox"/> Recall <input type="checkbox"/> Emergent <input type="checkbox"/> Consult	Pain Score: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (each visit)	
Procedure: ext #19 root tips	<input type="checkbox"/> Pain 4 or More: <input type="checkbox"/> Tolerated <input type="checkbox"/> Treatment see below <input type="checkbox"/> Medication Rx <input type="checkbox"/> Referred to	
Allergies: NKDA		
Dental Diagnosis(es): Root tip #19	B/P: 90/55	Pulse: 73
Medical Diagnosis(es): TICA/HG	Temp: 98.6	Resp: 18
Current Medications: <input type="checkbox"/> Patient takes no medications	AHA Prop: <input type="checkbox"/> N/A <input type="checkbox"/> Taken:	
<input type="checkbox"/> No medication changes since last visit	X-Rays today: <input checked="" type="checkbox"/> None <input type="checkbox"/> FMX <input type="checkbox"/> Bitewings (2)(4)	
<input type="checkbox"/> Current medication list is in medical record: verify/check every visit	<input type="checkbox"/> Panorex <input type="checkbox"/> Periapical(s) Location:	
<input type="checkbox"/> Patient has or was given copy of medication list: verify/check every visit	<input type="checkbox"/> Other:	
Time Out Site Verification: <input type="checkbox"/> completed prior to beginning procedure	Informed Consent Signed: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> N/A	
Prescription(s) written today: N/A		

Procedure Note: See Clinical Workstation.

Follow-up:	Education~Patient/Family verbalized understanding of the following issues:			
<input type="checkbox"/> Post-procedure instructions given to patient	<input checked="" type="checkbox"/> Treatment provided today <input type="checkbox"/> How/when to contact clinic/dentist			
<input type="checkbox"/> Special follow-up instructions:	<input type="checkbox"/> Individual oral hygiene instruction, adapted techniques & equipment			
<input type="checkbox"/> Make return visit in weeks    or months	<input type="checkbox"/> Tobacco cessation: Use tobacco? Y N if yes, Willing to Quit? Y N if yes, Info Given? Y N <input type="checkbox"/> Referral to 1-800-NO BUTTS			
Provider: 	Print Last Name: LOPEZ	Provider #: 528922	Date: 5/13/14	Time:
Attending:	Signature:	Print Last Name:	Provider #:	Date:
				Time:

PATIENT DATA – Imprint or Print Legibly	
Name: _____	
MRUN: 233 35 41 CENTER PATIENT IDENTIFICATION	
Date of Birth: 12/17/1966	
GOLD, KATHLEEN PHWR	
PREF. LANG: ENGLISH SEX: F	
Ward or C...	
Res. Loc. Code: _____	

Combines T-OV2268 and T-OV2269

Dental Center Program

OLIVE VIEW MEDICAL CENTER  
Printed: Tue May 13, 2014 11:23 AM

Demand Copy

MRUN=233-35-41

Acct #=7070879

Name=GOLD, KATHLEEN

DOB=12/17/1966

Age=47

Sex=F

FINAL REPORT

AMB CARE DENTAL EXTRACTION PROC NOTE

=====

Date of procedure: 5/13/14

Patient was offered a copy of the Dental Materials and Facts Sheet.  
Smoking Cessation information offered if the patient smokes.

S:

Pt. presents for extraction on tooth #19.

O:

MH: reviewed.

MH: Healthy.

A:

Patient has severe caries on remaining root tip #19. Tooth has a poor prognosis. Best treatment is extraction.

P:

Went over the risks, benefits, and alternatives of an extraction for tooth #19 with the patient. Gave the patient treatment options of observe or extract. Patient opted to extract tooth #19. Patient signed the consent form. Answered any questions the patient had. Gave topical anesthetic. Gave 1.5 carpules 1:100,000 2% lidocaine w/epi. Time out procedure completed. Showed the patient the tooth to be extracted with the patient mirror. Used the periosteal, straight elevator, and 151 forceps. Simple extraction. Irrigated extraction site with chlorhexidine oral rinse in a monojet. Placed pressure with gauze. Gave verbal and written post-op instructions. Answered all of the patient's questions. Patient left content.

Behavior: Good. Positive.

NV: No appointment made at this time.

Used Interpreter - Name: N/A

Used HCN - Interpreter ID #: N/A

Interpretation language: N/A

=====

Dictated By=LOPEZ, ABREY K. (DDS)  
Text Status=FINAL  
Elec Signed By= (Electronic Signature)  
LOPEZ, ABREY K. (DDS)  
Transcribed By=LOPEZ, ABREY K.

D/T=05/13/2014 1123

D/T=05/13/2014 1123

D/T=05/13/2014 1123

Printed By: Abrey K. Lopez, DDS  
Printed: 05/13/2014 11:23 AM

*Abrey Lopez* 528922 Confidential Patient Information  
NOT A CHART COPY

5/13/14 Page 1

Visit Type: <input checked="" type="checkbox"/> New <input type="checkbox"/> Established <input type="checkbox"/> Recall <input type="checkbox"/> Emergent <input type="checkbox"/> Consult	Procedure: Emergency exam # 19	Time: 10:10	<input type="checkbox"/> IP <input checked="" type="checkbox"/> OP <input type="checkbox"/> Unable to assess PAIN/VS due to patient disability
		Pain Score <input type="checkbox"/> 0 <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (each visit)	
Allergies: Soy, Gluten		<input type="checkbox"/> Pain 4 or More: <input type="checkbox"/> Tolerated <input type="checkbox"/> Treatment see below <input type="checkbox"/> Medication Rx <input type="checkbox"/> Referred to	
Medical Diagnosis(es): Root tips # 19		B/P: 95/59	Pulse: 71
Medical Diagnosis(es): Healthy		Temp: <input type="checkbox"/> N/A	Resp: <input type="checkbox"/> Weight: <input type="checkbox"/> N/A
Current Medications: <input type="checkbox"/> Patient takes no medications No medication changes since last visit		AHA Proph: <input type="checkbox"/> N/A <input type="checkbox"/> Taken	
Current medication list is in medical record: verify/check every visit		X-Rays today: <input type="checkbox"/> None <input type="checkbox"/> FMX <input type="checkbox"/> Bitewings (2)(4) <input type="checkbox"/> Panorex <input checked="" type="checkbox"/> Periapical(s) Location: # 19	
Patient has or was given copy of medication list: verify/check every visit		<input type="checkbox"/> Other: <input type="checkbox"/> (1)	
Leave Out Site Verification: <input type="checkbox"/> completed prior to beginning procedure		Informed Consent Signed: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	
Prescription(s) written today: <input type="checkbox"/> N/A			

Procedure Note: *see Clinical Note/abortion*

Follow-up:  
Post-procedure instructions given to patient  
Special follow-up instructions: \_\_\_\_\_

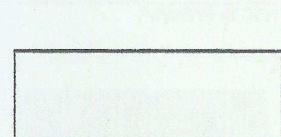
Education - Patient/Family verbalized understanding of the following issues:  
 Treatment provided today  How/when to contact clinic/dentist  
 Individual oral hygiene instruction, adapted techniques & equipment  
 Tobacco cessation: Use tobacco? Y N if yes, Willing to Quit? Y N  
 if yes, Info Given? Y N  Referral to 1-800-NO BUTTS

Make return visit in weeks  or months

Provider: *LOPEZ* Signature: *LOPEZ* Print Last Name: *LOPEZ* Provider #: *328922* Date: *4/11/14* Time: *11:14*

Tending:

Signature: *LOPEZ* Print Last Name: *LOPEZ* Provider #: *328922* Date: *4/11/14* Time: *11:14*



Refines T-OV2268 and T-OV2269

PATIENT DATA - Imprint or Print Legibly	
Name: <i>MID-VALLY COMP. - CENTER PATIENT IDENTIFICATION</i>	
MRN:	233 35 41
Date of Birth:	DOB: 12/17/1966
Ward or Room:	<i>GOLD, KATHLEEN ER</i>
PREF. LANG: ENGLISH SEX: F	
Ref. Loc. Code: _____	

Dental Center Prog.

TO BE COMPLETED BY PARENT OR GUARDIAN (if patient is a minor):

RESPONDAN LAS SIGUIENTES PREGUNTAS LOS PADRES O GUARDIANES (si el paciente es menor de edad):

Please explain any "yes" answers questions 3-11

1. What age is the patient?

¿Qué edad tiene el paciente?

42 yrs  
añosmos  
meses

2. Is patient now in good health?

¿Está el paciente ahora en buena salud?

si  yes  no

3. Has patient been sick or under the care of a physician within the past two years?

¿Ha estado el paciente enfermo o bajo el cuidado de un médico durante los ultimos dos años?

si  yes  no

4. Has patient had serious illness or an operation?

¿Ha tenido el paciente alguna enfermedad grave o alguna operacion?

si  yes  no

5. Has patient had excessive bleeding after a cut, injury, or tooth extraction?

¿Ha sangrado demasiado el paciente despues de una cortada, o un golpe o una extraccion de diente?

si  yes  no

6. Is patient subject to any nervous disorder, fainting, or dizziness?

¿Está el paciente sujeto a alguna enfermedad nerviosa, desmayos o mareos?

si  yes  no

7. Is patient taking any drug or medication?

¿Está el paciente tomado alguna medicina o droga?

si  yes  no

8. Is patient sensitive or allergic to penicillin, novacaine, or other drugs?

¿Es el paciente sensitivo o alergico a la penicilina, anestesia o otras drogas?

si  yes  no

9. Has patient a history of heart trouble (including rheumatic fever), high blood pressure, diabetes, asthma, tuberculosis, kidney or liver involvement, or any other constitutional disorder? (If answer is yes, underline condition.)

¿Tiene el paciente una historia de enfermedad del corazón (incluyendo fiebre reumática), alta presion, diabetes, asma, tuberculosis, desorden en los riñones o hígado? (Si la respuesta es si, describalo en las lineas abajo.)

si  yes  no

10. Has patient had unfavorable reaction from previous dental treatment?

¿Ha tenido el paciente alguna reacción desfavorable a algun tratamiento dental anterior?

si  yes  no

11. Has patient had a history of hepatitis or venereal disease?

¿Ha tenido el paciente alguna historia de hepatitis, o enfermedad venerea?

si  yes  no

12. Is the patient pregnant? (If female)

¿Está el paciente embarazada? (Si es mujer)

 Uncertain Insegurasi  yes  no

13. Details concerning any serious illness:

Detalles concernientes a alguna enfermedad grave:

SIGNATURE:

NAME:

RELATIONSHIP:

RELACION:

PATIENT ADDRESS:

DIRECCION DEL PACIENTE:

PATIENT PHONE NO.:

NUMERO DEL PACIENTE:

PATIENT NAME:  
NOMBRE DEL PACIENTE:DATE:  
FECHA:

4/11/2014

PATIENT DATA - Imprint or Print Legibly

Name:

MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION

233 35 41 DOB: 12/17/1966

GOLD, KATHLEEN ER

PREF. LANG: ENGLISH SEX: F



Date of B

Ward or C.

Req. Loc. Code:

REVIEWING DENTIST'S SIGNATURE

4/11/14

DATE



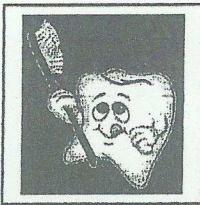
T-OV1072

FILE IN MEDICAL HISTORY

PAGE 1 OF 1

OV1072 (6-07)

DENTAL MEDICAL HISTORY



Dr. Abrey Lopez  
MidValley Comprehensive Health Center  
7515 Van Nuys Blvd.  
3rd Floor  
Van Nuys, CA 91405  
Phone: (818) 947-4028  
Fax: (818) 989-8847  
Date Faxed to Specialist: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient's Full Name: Kathleen Gold Date: 4/1/14

DOB: 12/17/66 Patient's Phone Number: \_\_\_\_\_

Referred To: USC Referred's Phone Number: \_\_\_\_\_

Type Of Specialty: School of Dentistry

- |                                       |                                       |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Endodontist  | <input type="checkbox"/> Pedodontist  |
| <input type="checkbox"/> Oral Surgeon | <input type="checkbox"/> Periodontist |
| <input type="checkbox"/> Orthodontist | <input type="checkbox"/> Other        |

If Other, For What Specialty?: \_\_\_\_\_

Right Side	Upper								Left Side																				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	24	23	22	21	20	19	18	17					
	32	31	30	29	28	27	26	25																					
Lower																													

Type of Treatment Needed: Pt would benefit from a comprehensive exam + treatment. Pt has remaining root tips for #19 + pt is interested in an implant consultation. Pt is aware #19 needs to be extracted.

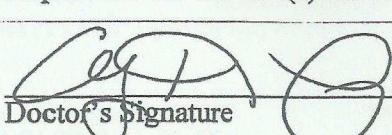
Appointment Information:

- Patient Will Call To Make Appointment  
 Appointment Made

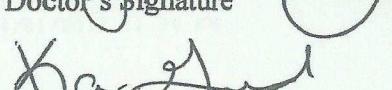
Appointment Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time: \_\_\_\_\_ Day: \_\_\_\_\_

The patient has a right to choose a specialist of their choice. The patient is responsible for following up with a specialist and obtaining dental treatment for the tooth or teeth that are being referred out for treatment. If the patient does not follow up, a dental infection can form which can spread and become life threatening. MidValley Dental Clinic will not be held responsible if the patient does not seek follow up care with a specialist. MidValley Dental Clinic is not responsible for the cost(s) of services outside their facility.

MID-VALLEY CORP. - CENTER PT. IDENTIFICATION  
DOB: 12/17/1966  
233 35 41  
GOLD, KATHLEEN PHWR  
PREF LANG: ENGLISH SEX: F

  
Doctor's Signature

4/1/14  
Date

  
Patient's Signature

4/1/14  
Date

OLIVE VIEW MEDICAL CENTER  
Printed: Tue Apr 1, 2014 11:59 AM

Demand Copy

Name=GOLD, KATHLEEN

DOB=12/17/1966

Age=47

Sex=F

MRUN=233-35-41

Acct #=7070879

## FINAL REPORT

## AMB CARE DENTAL EMERGENCY EXAM CLIN NOTE

Date of clinic visit: 4/1/14

Patient was offered a copy of the Dental Materials and Facts Sheet.  
Smoking Cessation information offered if the patient smokes.

S:

Pt. presents for emergency exam on tooth #19. Pt referred to USC School of Dentistry for an implant consultation.

O:

MH: reviewed. MH: Healthy.

A: Pt has root tips remaining on #19. Pt requires an ext and is interested in replacement. No abscess or pain present at this time.

P:

Took 1 periapical film. Oral and radiographic exams revealed pt has carious root tips remaining on #19. Let the patient know the treatment options are to observe or extract. Pt stated she is interested in replacing the space if the tooth is extracted. Pt is interested in an implant consultation. Let the patient know she would benefit from a comprehensive exam and treatment at USC School of Dentistry and she could see if she would be a good candidate for an implant. Pt most likely would need a bone graft prior to an implant. Pt would like a referral. Let the patient know if sh has any discomfort or an abscess forms on #19, she needs to have #19 extracted. An infection can form and spread and become life threatening if the tooth is not extracted. The patient understood. Answered all of the patient's questions and filled out a referral form for the patient.

Behavior: Good. Positive.

Next visit: No appt made.

Used Interpreter - Name:N/A  
Used HCN - Interpreter ID #:N/A  
Interpretation language: N/A

=====  
Dictated By=LOPEZ, ABREY K. (DDS) D/T=04/01/2014 1159  
Text Status=FINAL  
Elec Signed By= (Electronic Signature) D/T=04/01/2014 1159  
LOPEZ, ABREY K. (DDS)  
Transcribed By=LOPEZ, ABREY K. D/T=04/01/2014 1159

Printed By: Abrey K. Lopez, MD  
Printed: 04/01/2014 11:58 AM

Confidential Patient Information  
NOT A CHART COPY

Page 1

Patient Acknowledgement of  
Receipt of Dental Materials Fact Sheet

I, Kathy Goud

Patient's Name (Parent or Guardian if patient is a minor)

acknowledge I have received from MidValley Dental Clinic a  
copy of the Dental Materials Fact Sheet Dated October 2001.

Kathy Goud  
Patient's (or Parent's) Signature

4/1/2014  
Date

MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION  
233 35 41 DOB: 12/17/1966  
GOLD, KATHLEEN ER  
PREF. LANG: ENGLISH SEX: F



Nursing Intake: Gravida <u>2</u> Para <u>0</u> (TSAB <u>0</u> )				Date: <u>12/26/13</u>	Time: <u>10:00 AM</u>
Reason for visit: <u>New</u> <u>meds</u> <u>note</u>					
LMP: <u>2/2/02</u>		Age: <u>47</u>	BP: <u>125/50</u>	Pain: <u>0/10</u>	Goal: <u>0/10</u>
Birth Control Method: <u>Hormone</u>		Weight: <u>187 lbs</u>		Print Name: <u>NA LVN/RN</u>	
Signature: <u>Lynn</u> NA LVN/RN					

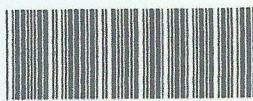
Since your last visit, have any of the following occurred to you? (Please complete the appropriate section according to patient's method)

All methods:		Hormonal Method: (HRT/Depo/Patch/OCP) <input checked="" type="checkbox"/> N/A				
N/A	Y	N	<input type="checkbox"/> <input type="checkbox"/> Failed to use method <input type="checkbox"/> <input checked="" type="checkbox"/> New sex partner <input type="checkbox"/> <input checked="" type="checkbox"/> Hospitalization (since last visit) <input type="checkbox"/> <input checked="" type="checkbox"/> New medication or drug <input type="checkbox"/> <input checked="" type="checkbox"/> Abnormal vaginal discharge or itch <input type="checkbox"/> <input checked="" type="checkbox"/> Do you need Emergency Contraception?			
Condom/Diaphragm:		<input checked="" type="checkbox"/> N/A				
Y	N	<input type="checkbox"/> <input type="checkbox"/> Break or slip <input type="checkbox"/> <input type="checkbox"/> Rash or discomfort				
For women with an IUD:		<input checked="" type="checkbox"/> N/A				
Y	N	<input type="checkbox"/> <input type="checkbox"/> String missing or partner feels string <input type="checkbox"/> <input type="checkbox"/> Severe abdominal pain				
Signature: <u>Lynn</u>		Print name and title				
Natural Family Planning:		<input checked="" type="checkbox"/> N/A				
Y	N	<input type="checkbox"/> <input type="checkbox"/> Are your periods ever more than 35 or less than 25 days apart? <input type="checkbox"/> <input type="checkbox"/> Have you had sex during unsafe days in your cycle?				
Currently seek pregnancy:		<input checked="" type="checkbox"/> N/A				
Y	N	<input type="checkbox"/> <input type="checkbox"/> Are your periods ever more than 35 or less than 25 days apart?				

Additional subjective data:

Patent is here requesting a letter to  
 Confirm that her last period was on 2/2/02 -  
 for court as a Court evidence.

Physical Exam: (N=Normal; A=Abnormal, No mark=Not Examined)		Lab Results:	
<input checked="" type="checkbox"/> N A <input type="checkbox"/> <input type="checkbox"/> Breasts <input type="checkbox"/> <input type="checkbox"/> Abdomen <input type="checkbox"/> <input type="checkbox"/> Vulva <input type="checkbox"/> <input type="checkbox"/> Vagina <input type="checkbox"/> <input type="checkbox"/> Cervix <input type="checkbox"/> <input type="checkbox"/> Uterus <input type="checkbox"/> <input type="checkbox"/> Adnexa <input type="checkbox"/> <input type="checkbox"/> Other		<u>11/05/13</u> Mammogram <u>ng (-)</u> <u>2/20/04</u> Pap <u>all slide</u> <u>clean</u> . <u>FSH - 46</u>	
<div style="border: 1px solid black; padding: 5px; margin-top: 10px;">           PATIENT DATA - Imprint or Print Legibly            Name: <u>MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION</u>            MRUN: <u>233 35 41</u> DOB: <u>12/17/1966</u>            Date of E: <u>GOLD, KATHLEEN ER</u>            Ward or C: <u>PREF. LANG: ENGLISH SEX: F</u>            Req. Loc. Code:  </div>			



T-OV2119

FILE IN MEDICAL RECORD

PAGE 1 OF 2

OV2119 (6-07)

WOMEN'S REVISIT RECORD

Assessment:

Requested a letter  
For Civil Court  
to inform that she  
L141 was 7002.

Plan:

- Pregnancy Test
- Pap smear
- GC PCR w/ amplif.
- CT PCR w/ amplif.
- Urine Dip
- Depo/150mg IM x \_\_\_\_\_
- Pill refill
- Plan B
- Foam / Condom # \_\_\_\_\_
- Other: \_\_\_\_\_

Patient Education: (N=Ordered for Nurse; P=Done by Provider)

- N P
- Discussion of Lab results
  - Discussion of Radiology results
  - Method related counseling
  - STI protection
  - Other \_\_\_\_\_

As this is a  
objection and  
her request is  
granted.  
Patient will get  
such a letter from  
local police  
who has not followed  
her for more than  
10 years

Nursing DispositionLabs:Radiology:

- Radiology slips given with instructions

- Order

# \_\_\_\_\_

Patient Education:

- Medication (#)

- Method related counseling done

- Education completed as ordered

Other \_\_\_\_\_

Patient Expressed Understanding By:

- Repeating information

- Repeat demonstration

Other \_\_\_\_\_

Signature RN/LVN: *Clayton*

Print Name: \_\_\_\_\_

12/26/13

1010

Date

Time

RTC:

As needed.

Provider  
Signature: \_\_\_\_\_

Date/Time: 12/26/13

Print Name: \_\_\_\_\_

1010

Attending MD: \_\_\_\_\_

Date/Time: \_\_\_\_\_

## WOMEN'S Health Assessment Record

(N=Normal or No Significant findings A=Abnormal, if abnormal please comment. NO MARK=NOT EXAMINED)

Physical Exam:	N	A	History/Exam/Abnormal Findings:	Nursing Intake:
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	History reviewed	T97.0
Thyroid:	<input type="checkbox"/>	<input type="checkbox"/>	46 y. here for annual f	
Breast:	<input type="checkbox"/>	<input type="checkbox"/>	OB/gyne h/o	
Skin Changes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	ABX 2	
Masses	<input type="checkbox"/>	<input type="checkbox"/>		
Nipple Discharge	<input type="checkbox"/>	<input type="checkbox"/>		
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>		
Heart:	<input type="checkbox"/>	<input type="checkbox"/>		
Rate/Rhythm	<input type="checkbox"/>	<input type="checkbox"/>		
Murmur	<input type="checkbox"/>	<input type="checkbox"/>		
Lungs:	<input type="checkbox"/>	<input type="checkbox"/>		
Auscultation	<input type="checkbox"/>	<input type="checkbox"/>		
Abdomen:	<input type="checkbox"/>	<input type="checkbox"/>		
Liver/Spleen	<input type="checkbox"/>	<input type="checkbox"/>		
Masses	<input type="checkbox"/>	<input type="checkbox"/>		
CVA Tenderness	<input type="checkbox"/>	<input type="checkbox"/>		
Genitalia:	<input type="checkbox"/>	<input type="checkbox"/>		
External Appearance	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Urethra	<input type="checkbox"/>	<input type="checkbox"/>		
Barthol's/Skene's	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Vagina	<input type="checkbox"/>	<input type="checkbox"/>		
Cervix	<input type="checkbox"/>	<input type="checkbox"/>		
Adnexa	<input type="checkbox"/>	<input type="checkbox"/>		
Uterus:	<input type="checkbox"/>	<input type="checkbox"/>		
Size	<input type="checkbox"/>	<input type="checkbox"/>		
Contour	<input type="checkbox"/>	<input type="checkbox"/>		
Mobility	<input type="checkbox"/>	<input type="checkbox"/>		
Rectal:	<input type="checkbox"/>	<input type="checkbox"/>		
External Appearance	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Digital Exam	<input type="checkbox"/>	<input type="checkbox"/>		
Extremities:	<input type="checkbox"/>	<input type="checkbox"/>		
Edema	<input type="checkbox"/>	<input type="checkbox"/>		
Pulses	<input type="checkbox"/>	<input type="checkbox"/>		
Skin:	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		

46 y. here for annual f  
OB/gyne h/o  
ABX 2  
Fmp  
Fmho breast of  
cranica 76  
STD's h/o -  
pap - last pap @ age 38  
mamm -  
8k activity - abstinance 710yr  
social - smoking  
urine incont -  
depression -  
A/P well f xam  
OB - NL  
pelvic f xam - limited  
2<sup>o</sup> right  
lithotomy  
② Postmenopausal  
estrogen  
Nursing Intake:  
Patient Type  
New Patient   
Annual   
Family Planning   
Postpartum   
Postabortion   
Age: 46  
G 2 P 0 (S) TAB 2  
Allergies:  
Glutin/Sn/egg white  
BP: 95/55 P72  
Weight: 185  
Height: 5'2  
Pain Level: 0/10  
Pain Goal: 0/10  
LMP: 2002  
Current Birth Control Method:  
N/A  
Date of last pill  
Date of last DMPA  
Date of last IUD insertion  
Any problems with birth  
control method?  
 Yes  No If yes,  
What kind?  
RN/LVN/NA  
Signature  
Print Name NOV 04 2013  
Date 1829  
Time

PATIENT DATA - Imprint or Print Legibly

Name: MID-VALLY COMP. - CENTER PATIENT IDENTIFICATION MRN. 233 35 41 DOB: 12/17/1966
MRN. GOLD, KATHLEEN ER Date of PREF. LANG: ENGLISH SEX: F
Ward or Clinic:
Req. Loc. Code:



T-OV2109

FILE IN MEDICAL RECORD

PAGE 1 OF 2

OV2109 (8-06)

Latitis B 1cc IM x 3

Birth Control Method: U/D

③ cont. 1u u/pmp - labs.  
No smoking - 18D No Births

#### NURSING DISPOSITION:

##### LABS:

PAP

L31993

Other: \_\_\_\_\_

Lab order (#) \_\_\_\_\_

Provider orders reinforced

##### RADIOLOGY:

Radiology slips given with instructions

Order # \_\_\_\_\_

#### PATIENT EDUCATION / INSTRUCTIONS

Medication (#) \_\_\_\_\_ or Rx(#)

Foams/Condoms (#) \_\_\_\_\_

Provider orders reinforced

Method related counseling done?

Yes  No

Other \_\_\_\_\_

#### LABS/TEST:

PAP  
 GC DNA w/ amplification  
 CT DNA w/ amplification  
 RPR  
 HIV, combined, w/ pre & post test counseling  
 Other FSH

HSV Culture  
 Pregnancy Test  
 Urine Dip  
 Hg/Hct (IUD)  
 FBS (OCP/Depo)  
 Cholesterol (OCP)

#### 2/Concurrent Dx:

Wet Mount  
 U/A  
 Urine C & S  
 CBC/ESR

#### Adult Health Assessment

Stool Occult Blood x 3  
 Fasting lipid panel

#### RADIOLOGY:

Pelvic Ultrasound  
 Screening Mammogram  
 Other

NOV 5, 2013 @ 946

Diagnostic Mammogram

Topic	Discussed/Handout/Video
Diet	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
BSE	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
Domestic Violence	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
STI	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
Birth Control	
Method	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pain	
Management	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

#### PATIENT EDUCATION: N=ordered for Nurse; P=done by provider

N P  
 Physical Exercise/Nutrition  
 Breast Self Exam  
 Domestic Violence  
 Pain Management  
 Cancer Prevention  
 Discussion of lab results  
 Discussion of radiology results

N P OTC B7D  
 Calcium supplementation  
 Smoking Cessation  
 HIV/STI Prevention  
 Birth Control Method: \_\_\_\_\_  
 Adolescent Counseling per protocol (≤17 yrs)  
 Other \_\_\_\_\_

N P  
 EC/Plan B

#### Patient expressed understanding by:

Repeating Information  
 Repeat Demonstration  
 Other

#### REFERRALS:

Nutritionist  Health Educator  HIV Referral List  Community Partners List  
 Social Worker  Specialist

Return to clinic: pm (timeframe)

#### RN/LVN/NA

Signature 11/4/13

RN/LVN/NA Signature 11/4/13

NOV 04 2013 Date

Time

Provider Signature: fran

Date: NOV 04 2013

MR# \_\_\_\_\_

Print Name: fran

Time: \_\_\_\_\_

DOB \_\_\_\_\_

Attending MD Signature: fran

Date: 7/10/13

Time: 7/10/13

OVMC LIVE  
RESULTS BY RESULT VIEW  
Printed Tue Oct 27, 2015 8:47 AM by MGP,MVMR

Name:GOLD, KATHLEEN  
35-41  
Loc: MVHC  
Acc#:7070879

Sex:F  
Adm:09/19/13

DOB:12/17/1966

MRUN:233-

COMPREHENSIVE VIEW Result View for 09/23/13 0001 - 10/27/15 0847 (Only the Results Shown on the Grid):

Test	Normal Range	11/05/13	11/05/13
		1008	0915
		OP	
<b>LABORATORY</b>			
BLOOD BANK			
BLOOD GAS			
Chemistry			
NA	(136-144)	137	
K	(3.6-5.1)	4.1	
CL	(97-108)	102	
BICARBONATE	(22-32)	28	
ANION GAP	(5-14)	@ 7	
BUN	(8-20)	14	
CREAT	(0.60-1.30)	0.74	
eGFR		@ 84	
GLU	(65-139)	@ 95	
CA	(8.9-10.3)	L 8.7	
AST	(15-41)	18	
ALT	(14-54)	15	
ALK PHOS	(38-126)	87	
T BILI	(0.1-1.2)	0.7	
D BILI	(0.1-0.4)	0.2	
T PROTEIN	(6.5-8.1)	L 6.3	
ALBUMIN	(3.5-4.8)	3.7	
CHOL		189	
TRIG		51	
HDL	(40-60)	@ 47	
LDL		@ 129	
VLDL		10	
CHOLESTEROL/HDL		@ 4.0	
NON-HDL CHOLEST		@H 142	
PATIENT FASTING		YES	
TSH	(0.550-4.780)	1.480	
<b>COAGULATION</b>			
POC/ANTICOAG			
CYTOLGY			
FLOW CYTO			
HEMATOLOGY			
WBC COUNT	(3.8-10.9)	9.4	
RBC COUNT	(3.66-5.34)	4.46	
Hgb	(11.2-16.0)	13.4	
HCT	(33.3-47.1)	40.9	
MCV	(77.5-99.5)	91.8	
MCH	(26.3-34.3)	30.0	
MCHC	(32.7-35.5)	32.7	

OVMC LIVE  
RESULTS BY RESULT VIEW  
Printed Tue Oct 27, 2015 8:47 AM by MGP,MVMR

Name: GOLD, KATHLEEN  
35-41  
Loc: MVHC  
Acc#: 7070879

Sex: F  
Adm: 09/19/13

DOB: 12/17/1966

MRUN: 233-

Att:

Test	Normal Range	11/05/13	11/05/13
		1008	0915
		OP	
RDW	(11.2-14.8)	14.4	
PLT COUNT	(141-401)	351	
MPV	(7.0-10.9)	8.0	

Microbiology  
PATHNET LABS  
POCT  
REF LABS  
FSH, SERUM  
SEROLOGY  
HGB A1C  
SURG PATH  
URINALYSIS  
Env Service  
CARDIOLOGY  
Neurology  
Nsg. Orders  
Prenatal  
Plmtry Fnctn  
TFU  
Radiology  
CT  
DIAG  
mri  
Nuc Med  
Rad/ER  
US  
RAD Mammo  
Call X-4096  
MAMMOGRAM SCREE  
sched diag  
sp

SIGNED

COMPREHENSIVE VIEW Result View for 09/23/13 0001 - 10/27/15 0847 (Only the Results Shown on the Grid):  
Page 2

OVMC LIVE  
RESULTS BY RESULT VIEW  
Printed Tue Oct 27, 2015 8:47 AM by MGP,MVMR

Name: GOLD, KATHLEEN  
35-41  
Loc: MVHC  
Acc#: 7070879

Sex: F  
Adm: 09/19/13

DOB: 12/17/1966

MRUN: 233 -

BP (Collected 11/05/13 1008, L143641-1):  
ANION GAP

Comment:  
ANION GAP =  $NA - (Cl + HCO_3)$

eGFR

Comment:  
If patient is African American,  
multiply the result by 1.21

Chronic Kidney Disease (CKD) Stages  
based on estimated GFR:

GFR ml/min/1.73m

30 - 59	3
15 - 29	4
<15 (or dialysis)	5

GLU

Comment:  $\geq 200$  Provisional diabetes

LIPID (Collected 11/05/13 1008, L143640-1):  
HDL

Comment:  
DECREASED RISK:  $>60$  mg/dL  
AVERAGE: 40-60 mg/dL  
INCREASED RISK:  $<40$  mg/dL

LDL

Comment:  
DESIRABLE:  $<130$  mg/dL  
BORDERLINE: 130-159 mg/dL  
HIGH RISK:  $>159$  mg/dL

CHOLESTEROL/HDL RATIO

Comment:  
GOAL:  $<5:1$   
OPTIMUM: 3.5:1

COMPREHENSIVE VIEW Result View for 09/23/13 0001 - 10/27/15 0847 (Only the Results Shown on the Grid):  
Page 3

OVMC LIVE  
RESULTS BY RESULT VIEW  
Printed Tue Oct 27, 2015 8:47 AM by MGP,MVMR

Name: GOLD, KATHLEEN  
35-41  
Loc: MVHC  
Acc#: 7070879

Sex: F  
Adm: 09/19/13

DOB: 12/17/1966

MRUN: 233-

NON-HDL CHOLESTEROL

Comment:  
DESIRABLE: <130 mg/dL  
BORDERLINE: 130-159 mg/dL  
HIGH: 160-189 mg/dL  
VERY HIGH: > or = 190 mg/dL

FSH, SERUM (Collected 11/05/13 1008, L319931-1):  
FSH: 45.5 miU/mL

Comment:

Reference Range:

FEMALES:  
FOLLICULAR: 3.5-12.5 miU/mL  
OVULATION: 4.7-21.5 miU/mL  
LUTEAL: 1.7-7.7 miU/mL  
POSTMENOPAUSAL: 25.8-135.0 miU/mL

COMMENTS: NONE  
ACCESSION NO. COMMENT:  
W223947

ANALYSIS PERFORMED BY:  
LOS ANGELES COUNTY-USC MEDICAL CENTER  
1200 N. STATE ST.  
LOS ANGELES, CA 90033  
PH: (323) 226-7023  
DIRECTOR: IRA A. SHULMAN, M.D.

HGB A1C (Collected 11/05/13 1008, L143638-1):  
HEMOGLOBIN A1C: H 6.0 (<5.7) %

Comment:  
Diabetics in good control may overlap the normal population.

American Diabetes Association (ADA) clinical practice guidelines are:  
Desirable: Less than 5.7%  
Increased risk for diabetes: 5.7% to 6.4%  
Provisional diabetes: 6.5% or higher

COMPREHENSIVE VIEW Result View for 09/23/13 0001 - 10/27/15 0847 (Only the Results Shown on the Grid):  
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